Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VA Boston HCS (VAMC Boston - 523 and VAMC W. Roxbury - 523A4), VAMC Brockton, MA - 523A5 and VAH Bedford, MA

VISN 1

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 1500

2. Point-in-time estimate of Veterans who are Chronically Homeless: 203

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **1500** (point-in-time estimate of homeless veterans in service area) **X 16%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 86%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 203** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	650	0
Transitional Housing Beds	828	75
Permanent Housing Beds	20	550

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 21

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Boston: Currently there are 50,000 applicants awaiting Section 8. Advocate for political action and seek some opportunities. Hold our weekly housing search group to ferret out openings. Bedford: Will research housing programs that assist veterans with history of sexual assault or arson.
VA disability/pension	Continue to proactively ID vets who are eligible and have them work with our supportive housing people to follow through with DVB.
Drop-in Center or Day Program	Seek to retain our drop-in center as our VAMC consolidates sites. This could mean developing such a site in the community.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 36 Non-VA staff Participants: 86% Homeless/Formerly Homeless: 31%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.03	52%	2.25	1
2	Dental care	2.03	12%	2.34	2
3	Child care	2.14	0%	2.39	3
4	Legal assistance	2.63	8%	2.61	4
5	Job training	2.68	12%	2.88	14
6	Help with transportation	2.7	0%	2.82	11
7	Education	2.78	8%	2.88	13
8	Glasses	2.83	8%	2.67	6
9	Family counseling	2.84	4%	2.85	12
10	Help with finding a job or getting employment	2.87	15%	3.00	17
11	Eye care	2.9	4%	2.65	5
12	Guardianship (financial)	2.93	0%	2.76	9
13	Halfway house or transitional living facility	2.97	15%	2.76	8
14	Welfare payments	3.03	0%	2.97	16
15	Women's health care	3.04	4%	3.09	21
16	Treatment for dual diagnosis	3.06	4%	3.01	18
17	Help managing money	3.06	0%	2.71	7
18	Discharge upgrade	3.1	0%	2.90	15
19	Services for emotional or psychiatric problems	3.13	12%	3.20	25
20	Spiritual	3.14	8%	3.30	27
21	Drop-in center or day program	3.2	0%	2.77	10
22	VA disability/pension	3.2	12%	3.33	29
23	Help getting needed documents or identification	3.23	0%	3.16	23
24	SSI/SSD process	3.26	0%	3.02	19
25	Help with medication	3.3	4%	3.18	24
26	Detoxification from substances	3.31	8%	3.11	22
27	Hepatitis C testing	3.32	0%	3.41	32
28	Emergency (immediate) shelter	3.36	12%	3.04	20
29	Treatment for substance abuse	3.45	0%	3.30	28
30	AIDS/HIV testing/counseling	3.47	0%	3.38	30
31	TB treatment	3.57	0%	3.45	33
32	Medical services	3.58	0%	3.55	34
33	Personal hygiene (shower, haircut, etc.)	3.66	0%	3.21	26
34	Clothing	3.72	4%	3.40	31
35	Food	3.83	0%	3.56	35
36	TB testing	3.93	0%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.57	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.31	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.88	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.88	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.06	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.78	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.68	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.85	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.93	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.33	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	3.04	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.63	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.4	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.31	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.68	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.12	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.92	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.23	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.04	1.84

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CHALENG 2004 Survey: VA Connecticut HCS (VAMC Newington and VAMC West Haven)

VISN 1

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 4500

2. Point-in-time estimate of Veterans who are Chronically Homeless: 1623

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **4500** (point-in-time estimate of homeless veterans in service area) **X 39%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 93%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 1623** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	1864	220
Transitional Housing Beds	996	375
Permanent Housing Beds	20	2800

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 11

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue to work closely with Connecticut Coalition to End Homelessness and the "Reading Home" Campaign that is being lead by the Partnership for Strong Communities. Advocate for veteran's inclusion in the new Safe Haven program in New Haven.
Dental Care	As we enter a new fiscal year, meet with chief of dental services to discuss VHA Directive 2002-080 and to negotiate homeless veterans' access to dental services.
Services for emotional or psychiatric problems	This year, a psychosocial rehabilitation fellow will work with VA Healthcare for Homeless Veterans team. She will provide outreach, engagement and clinical services to veterans who are not connected to VA, yet are symptomatic. Her focus will be Motivational Interviewing. Continue to attend educational opportunities on harm reduction/housing first. Work closely with Safe Haven due to open in December 2004.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 52 Non-VA staff Participants: 70% Homeless/Formerly Homeless: 15%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	2.08	2%	2.34	2
2	Child care	2.12	0%	2.39	3
3	Long-term, permanent housing	2.19	45%	2.25	1
4	Help managing money	2.35	0%	2.71	7
5	Help with transportation	2.35	4%	2.82	11
6	Guardianship (financial)	2.48	0%	2.76	9
7	Education	2.51	0%	2.88	13
8	Eye care	2.57	2%	2.65	5
9	Family counseling	2.6	0%	2.85	12
10	Legal assistance	2.64	0%	2.61	4
11	Halfway house or transitional living facility	2.67	13%	2.76	8
12	Help with finding a job or getting employment	2.72	11%	3.00	17
13	Glasses	2.74	4%	2.67	6
14	Discharge upgrade	2.74	2%	2.90	15
15	Drop-in center or day program	2.76	9%	2.77	10
16	Welfare payments	2.76	0%	2.97	16
17	Job training	2.77	2%	2.88	14
18	SSI/SSD process	2.89	2%	3.02	19
19	Emergency (immediate) shelter	2.94	22%	3.04	20
20	VA disability/pension	2.98	4%	3.33	29
21	Women's health care	3	0%	3.09	21
22	Treatment for dual diagnosis	3.06	17%	3.01	18
23	Help getting needed documents or identification	3.06	2%	3.16	23
24	Help with medication	3.14	4%	3.18	24
25	Detoxification from substances	3.22	4%	3.11	22
26	AIDS/HIV testing/counseling	3.23	0%	3.38	30
27	TB treatment	3.23	0%	3.45	33
28	Personal hygiene (shower, haircut, etc.)	3.24	2%	3.21	26
29	Clothing	3.24	2%	3.40	31
30	Services for emotional or psychiatric problems	3.25	17%	3.20	25
31	Treatment for substance abuse	3.27	15%	3.30	28
32	Spiritual	3.29	2%	3.30	27
33	Hepatitis C testing	3.39	7%	3.41	32
34	Food	3.46	4%	3.56	35
35	TB testing	3.47	0%	3.58	36
36	Medical services	3.62	0%	3.55	34

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.35	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.26	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.91	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.21	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.09	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.09	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.96	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.74	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.81	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.09	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.29	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.65	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.47	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.58	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.68	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.34	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.72	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.56	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.45	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.88	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAM&ROC Togus, ME - 402

VISN 1

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 40

2. Point-in-time estimate of Veterans who are Chronically Homeless: 13

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **40** (point-in-time estimate of homeless veterans in service area) **X 41%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 76%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 13** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	400	0
Transitional Housing Beds	25	0
Permanent Housing Beds	5	5

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 3

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	Continue to pursue formal/informal agreements with community providers; offer education presentations on Grant and Per Diem NOFAs.
Long-term, permanent housing	Secure five-bed permanent housing dwelling.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 22 Non-VA staff Participants: 100%
Homeless/Formerly Homeless: 5%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.14	50%	2.25	1
2	Dental care	2.24	0%	2.34	2
3	Child care	2.29	5%	2.39	3
4	Eye care	2.48	0%	2.65	5
5	Halfway house or transitional living facility	2.5	65%	2.76	8
6	Legal assistance	2.62	0%	2.61	4
7	Family counseling	2.71	0%	2.85	12
8	Guardianship (financial)	2.8	0%	2.76	9
9	Help managing money	2.8	0%	2.71	7
10	Glasses	2.81	0%	2.67	6
11	Help with transportation	2.81	15%	2.82	11
12	Women's health care	2.86	0%	3.09	21
13	Drop-in center or day program	2.9	0%	2.77	10
14	Discharge upgrade	2.95	0%	2.90	15
15	Education	3	0%	2.88	13
16	Spiritual	3	5%	3.30	27
17	Treatment for dual diagnosis	3.1	0%	3.01	18
18	Help with medication	3.14	0%	3.18	24
19	Personal hygiene (shower, haircut, etc.)	3.19	10%	3.21	26
20	Services for emotional or psychiatric problems	3.19	0%	3.20	25
21	Medical services	3.19	5%	3.55	34
22	TB testing	3.19	0%	3.58	36
23	Help getting needed documents or identification	3.19	0%	3.16	23
24	TB treatment	3.24	0%	3.45	33
25	Welfare payments	3.24	0%	2.97	16
26	SSI/SSD process	3.24	5%	3.02	19
27	Clothing	3.26	5%	3.40	31
28	AIDS/HIV testing/counseling	3.29	0%	3.38	30
29	Emergency (immediate) shelter	3.32	20%	3.04	20
30	Detoxification from substances	3.33	0%	3.11	22
31	Hepatitis C testing	3.33	0%	3.41	32
32	Food	3.38	5%	3.56	35
33	Job training	3.38	5%	2.88	14
34	Treatment for substance abuse	3.43	0%	3.30	28
35	VA disability/pension	3.43	5%	3.33	29
36	Help with finding a job or getting employment	3.48	5%	3.00	17

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.18	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	2.77	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.5	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.09	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.59	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.86	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.19	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.24	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.67	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.16	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.8	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.33	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.76	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.81	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.45	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.95	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.55	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.47	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.56	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.65	1.84

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CHALENG 2004 Survey: VAM&ROC White River Junction, VT - 405

VISN 1

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 15

2. Point-in-time estimate of Veterans who are Chronically Homeless: 0

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **15** (point-in-time estimate of homeless veterans in service area) **X 0%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 75%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 0** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	30	0
Transitional Housing Beds	26	0
Permanent Housing Beds	0	5

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	Access Grant and Per Diem funds for project near White River Junction.
Treatment for substance abuse	Expand substance abuse counseling in communities with VA outreach clinicians.
VA disability/pension	Screen all veterans for possible benefits eligibility.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 0 Non-VA staff Participants: N/A . Homeless/Formerly Homeless: N/A .

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
	Personal hygiene (shower, haircut, etc.)	.	.	3.21	26
	Food	.	.	3.56	35
	Clothing	.	.	3.40	31
	Emergency (immediate) shelter	.	.	3.04	20
	Halfway house or transitional living facility	.	.	2.76	8
	Long-term, permanent housing	.	.	2.25	1
	Detoxification from substances	.	.	3.11	22
	Treatment for substance abuse	.	.	3.30	28
	Services for emotional or psychiatric problems	.	.	3.20	25
	Treatment for dual diagnosis	.	.	3.01	18
	Family counseling	.	.	2.85	12
	Medical services	.	.	3.55	34
	Women's health care	.	.	3.09	21
	Help with medication	.	.	3.18	24
	Drop-in center or day program	.	.	2.77	10
	AIDS/HIV testing/counseling	.	.	3.38	30
	TB testing	.	.	3.58	36
	TB treatment	.	.	3.45	33
	Hepatitis C testing	.	.	3.41	32
	Dental care	.	.	2.34	2
	Eye care	.	.	2.65	5
	Glasses	.	.	2.67	6
	VA disability/pension	.	.	3.33	29
	Welfare payments	.	.	2.97	16
	SSI/SSD process	.	.	3.02	19
	Guardianship (financial)	.	.	2.76	9
	Help managing money	.	.	2.71	7
	Job training	.	.	2.88	14
	Help with finding a job or getting employment	.	.	3.00	17
	Help getting needed documents or identification	.	.	3.16	23
	Help with transportation	.	.	2.82	11
	Education	.	.	2.88	13
	Child care	.	.	2.39	3
	Legal assistance	.	.	2.61	4
	Discharge upgrade	.	.	2.90	15
	Spiritual	.	.	3.30	27

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	.	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	.	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	.	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	.	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	.	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	.	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	.	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	.	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	.	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	.	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	.	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	.	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	.	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	.	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	.	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	.	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	.	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	.	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	.	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	.	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Manchester, NH - 608

VISN 1

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 350

2. Point-in-time estimate of Veterans who are Chronically Homeless: 101

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **350** (point-in-time estimate of homeless veterans in service area) **X 33%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 86%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 101** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	580	0
Transitional Housing Beds	480	0
Permanent Housing Beds	5	350

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 1

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continues to be problem for New Hampshire which has been in a housing crisis for last few years, but a community agency has recently been approved for a capital grant to provide 20 units of permanent housing for homeless vets for FY 2005. State of NH has recently applied for a substance abuse grant which will apparently provide vouchers for a full range of supportive services and housing for homeless people including veterans. State of NH also recently submitted an application under the "Samaritan Initiative" to try to create permanent housing for homeless people including veterans. The three HUD Continuums in the state of NH have applied for bonus projects through HUD which may provide rent subsidies and supportive services. The United Way, NH Charitable Fund and other agencies have made, and will continue to make affordable permanent housing a top need! There is a statewide effort to somehow make NH housing more affordable and acessible to all citizens.
Dental Care	Continue to work with our local mobile community health care team in coordinating a limited number of referrals to local dental clinics associated with them. With our new VA Per Diem program, we may be able to refer some of our homeless veterans participating in this program to our VAMC Dental Clinic in the near future.
Help with Transportation	Will continue to work with DAV volunteers and seek grant money, if available, for our Per Diem Program. Will try to approach local transportation companies and explore possibility of reduced fares for homeless veterans.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 34 Non-VA staff Participants: 79%
Homeless/Formerly Homeless: 6%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	1.41	74%	2.25	1
2	Dental care	1.68	26%	2.34	2
3	Drop-in center or day program	1.88	6%	2.77	10
4	Help with transportation	2.24	12%	2.82	11
5	Child care	2.3	0%	2.39	3
6	Discharge upgrade	2.38	0%	2.90	15
7	Help managing money	2.43	0%	2.71	7
8	Detoxification from substances	2.53	9%	3.11	22
9	Guardianship (financial)	2.53	0%	2.76	9
10	Family counseling	2.58	0%	2.85	12
11	Halfway house or transitional living facility	2.68	21%	2.76	8
12	Glasses	2.76	0%	2.67	6
13	Eye care	2.85	0%	2.65	5
14	Welfare payments	2.88	0%	2.97	16
15	Job training	2.88	6%	2.88	14
16	SSI/SSD process	2.94	0%	3.02	19
17	Help with finding a job or getting employment	2.94	0%	3.00	17
18	Legal assistance	3	0%	2.61	4
19	Education	3.18	0%	2.88	13
20	Help getting needed documents or identification	3.24	0%	3.16	23
21	Treatment for substance abuse	3.26	9%	3.30	28
22	Treatment for dual diagnosis	3.3	0%	3.01	18
23	Services for emotional or psychiatric problems	3.38	3%	3.20	25
24	Emergency (immediate) shelter	3.47	15%	3.04	20
25	Personal hygiene (shower, haircut, etc.)	3.53	0%	3.21	26
26	VA disability/pension	3.54	3%	3.33	29
27	Help with medication	3.62	6%	3.18	24
28	Clothing	3.71	0%	3.40	31
29	Women's health care	3.96	0%	3.09	21
30	Medical services	4.09	0%	3.55	34
31	Hepatitis C testing	4.21	0%	3.41	32
32	Food	4.26	3%	3.56	35
33	TB treatment	4.28	0%	3.45	33
34	AIDS/HIV testing/counseling	4.29	0%	3.38	30
35	TB testing	4.31	0%	3.58	36
36	Spiritual	4.5	6%	3.30	27

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.62	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.21	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.32	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.5	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.26	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.4	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.06	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	4.1	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.36	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.14	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.21	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.57	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.07	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.32	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.14	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.04	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.32	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.61	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Northampton, MA - 631 (Leeds)

VISN 1

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 130

2. Point-in-time estimate of Veterans who are Chronically Homeless: 36

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **130** (point-in-time estimate of homeless veterans in service area) **X 28%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 99%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 36** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	130	0
Transitional Housing Beds	145	0
Permanent Housing Beds	70	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Treatment for Dual Diagnosis	This has been an ever increasing need for the past 3-4 years. There has been an increase in groups for dual diagnosis and there is a new house opening in New Hampshire called Veterans Victory Farm which will have 20 beds for dual diagnosis veterans.
Help with finding a job or getting employment	Our goal is to increase the scope of job possibilities and full-time employment position by expanding out further than the immediate areas of the shelter; and provide reasonable transportation, to and from, these jobs, so that veterans can be more responsible and assist them in moving on with their lives, to permanent housing and own transportation.
Legal Assistance	Would like to see more availability of legal assistance because there are many veterans coming from jail or were thrown out of their homes for several reasons: retraining orders, separation or divorce papers, alcohol or drug abuse, etc. They have no money, no home, no job and no transportation -- thus, they feel like they just want to hang it up with no defense of themselves at all.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 25 Non-VA staff Participants: 88%
Homeless/Formerly Homeless: 4%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Child care	2.45	0%	2.39	3
2	Drop-in center or day program	2.67	0%	2.77	10
3	Discharge upgrade	2.71	14%	2.90	15
4	Family counseling	2.78	0%	2.85	12
5	Legal assistance	2.87	0%	2.61	4
6	Dental care	2.92	5%	2.34	2
7	Guardianship (financial)	2.95	5%	2.76	9
8	Treatment for dual diagnosis	3	10%	3.01	18
9	Job training	3	10%	2.88	14
10	Detoxification from substances	3.04	10%	3.11	22
11	Glasses	3.04	5%	2.67	6
12	Education	3.05	5%	2.88	13
13	Help with transportation	3.09	0%	2.82	11
14	Eye care	3.13	0%	2.65	5
15	VA disability/pension	3.13	5%	3.33	29
16	Help managing money	3.13	5%	2.71	7
17	Help with finding a job or getting employment	3.17	14%	3.00	17
18	Treatment for substance abuse	3.2	29%	3.30	28
19	Women's health care	3.22	5%	3.09	21
20	Welfare payments	3.22	5%	2.97	16
21	SSI/SSD process	3.22	0%	3.02	19
22	AIDS/HIV testing/counseling	3.26	0%	3.38	30
23	Services for emotional or psychiatric problems	3.33	14%	3.20	25
24	TB treatment	3.41	0%	3.45	33
25	Help with medication	3.42	0%	3.18	24
26	Hepatitis C testing	3.43	0%	3.41	32
27	Spiritual	3.43	0%	3.30	27
28	Long-term, permanent housing	3.46	33%	2.25	1
29	Help getting needed documents or identification	3.48	0%	3.16	23
30	Clothing	3.54	0%	3.40	31
31	Personal hygiene (shower, haircut, etc.)	3.57	5%	3.21	26
32	Medical services	3.58	5%	3.55	34
33	TB testing	3.7	0%	3.58	36
34	Emergency (immediate) shelter	3.76	10%	3.04	20
35	Halfway house or transitional living facility	3.83	10%	2.76	8
36	Food	3.96	0%	3.56	35

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.42	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.25	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.83	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.3	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.17	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.43	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.09	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.7	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.5	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.38	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.86	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.61	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.58	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.61	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.65	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.41	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.94	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.53	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.12	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.12	1.84

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CHALENG 2004 Survey: VAMC Providence, RI - 650, Bristol, CT

VISN 1

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 175

2. Point-in-time estimate of Veterans who are Chronically Homeless: 12

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **175** (point-in-time estimate of homeless veterans in service area) **X 7%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 95%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 12** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	2	10
Transitional Housing Beds	40	15
Permanent Housing Beds	0	20

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue to support new initiatives for development of permanent housing in Rhode Island. Inform public of waiting time to locate permanent housing. Explore developing memorandum of understanding with private developers who want to renovate older homes or construct new housing.
Transitional living facility	Continue to support local community and private agencies to apply for VA Grant and Per Diem funding.
Dental Care	Increase use of VA dental services. Promote use of RI donated dental.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 19 Non-VA staff Participants: 74%
Homeless/Formerly Homeless: 5%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Child care	1.95	0%	2.39	3
2	Long-term, permanent housing	2.05	61%	2.25	1
3	Dental care	2.11	6%	2.34	2
4	Welfare payments	2.68	0%	2.97	16
5	Family counseling	2.79	0%	2.85	12
6	Women's health care	2.79	6%	3.09	21
7	Eye care	2.79	0%	2.65	5
8	Glasses	2.79	0%	2.67	6
9	Legal assistance	2.84	0%	2.61	4
10	Spiritual	2.84	11%	3.30	27
11	Guardianship (financial)	2.89	0%	2.76	9
12	Education	2.95	0%	2.88	13
13	Discharge upgrade	3	0%	2.90	15
14	Drop-in center or day program	3.16	0%	2.77	10
15	Help managing money	3.21	0%	2.71	7
16	Halfway house or transitional living facility	3.22	50%	2.76	8
17	Job training	3.26	0%	2.88	14
18	Personal hygiene (shower, haircut, etc.)	3.37	0%	3.21	26
19	Emergency (immediate) shelter	3.37	11%	3.04	20
20	Help with transportation	3.42	0%	2.82	11
21	Food	3.47	17%	3.56	35
22	Clothing	3.47	11%	3.40	31
23	Help with finding a job or getting employment	3.47	6%	3.00	17
24	Help getting needed documents or identification	3.53	0%	3.16	23
25	Help with medication	3.58	6%	3.18	24
26	SSI/SSD process	3.58	6%	3.02	19
27	Detoxification from substances	3.63	6%	3.11	22
28	Medical services	3.68	11%	3.55	34
29	Treatment for dual diagnosis	3.74	0%	3.01	18
30	VA disability/pension	3.74	6%	3.33	29
31	Treatment for substance abuse	3.84	0%	3.30	28
32	Services for emotional or psychiatric problems	3.89	0%	3.20	25
33	Hepatitis C testing	3.95	0%	3.41	32
34	AIDS/HIV testing/counseling	4	0%	3.38	30
35	TB treatment	4.11	0%	3.45	33
36	TB testing	4.17	0%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.26	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.95	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.53	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.79	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.74	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.63	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.68	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	4.42	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.93	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	3.21	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.86	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	3.07	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.93	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.93	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.8	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.79	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.57	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.71	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.71	1.84